between infarction and haemorrhage in the three groups is essentially unchanged.

That treatment has different effects on different lesions caused by hypertension is perhaps not surprising. The most probable explanation is that the processes giving rise to atheroma are already established at the time when treatment is begun and that progression of these processes is unaffected by treatment. If so, preventive methods may require earlier intervention even before drug treatment would normally be considered. Further studies of possible reversible environmental factors in hypertension are required to define how practicable such measures are, but the burden of cerebrovascular disease in an aging population demands that these problems be examined scientifically.

References


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SHORT REPORTS

Campylobacter infection mimicking Crohn's disease in an immunodeficient patient

Campylobacter jejuni is a common cause of infectious diarrhoea. Usually, it is a self limiting infection, causing abdominal pain and diarrhoea for two to three days. We describe a patient with immunodeficiency in whom campylobacter infection had a chronic course and rectal biopsy showed granuloma; the infection thus mimicked Crohn's disease.

Case report

A 51 year old married carpenter was admitted to hospital for investigation of diarrhoea. He had been well until the sudden onset of painless, watery diarrhoea four months previously. He had lost 6-4 kg in weight. On examination he was pale and thin and had a temperature of 37.5°C. The liver was 3 cm enlarged, and the spleen was palpable 2 cm below the left costal margin. Rectal examination yielded normal results. At sigmoidoscopy the rectal mucosa looked normal but there was contact bleeding. A barium enema showed a featureless colon compatible with acute colitis. Rectal biopsy showed chronic inflammation with granuloma (figure). The histological appearances were consistent with Crohn's disease. Stool cultures grew Campylobacter spp. He was treated with erythromycin 500 mg twice daily for one week. Subsequent stool cultures yielded negative results. His symptoms improved, his gained weight, and his fever settled. Six months later a repeat rectal biopsy specimen was normal.

During the investigation an anterior mediastinal mass was found on chest radiography. Haemoglobin concentration was 7.3 g/dl, reticulocytes 1%. White cell count was 7·8x10^9/l with a lymphocyte count of 4·6x10^9/l: 79% were T cells, of which 12% were OKT4 and 88% OKT8, indicating a reversal of the normal helper to suppressor ratio. A bone marrow aspirate showed decreased normoblastic erythropoiesis, normal iron stores, and a high lymphocyte count (25%). Immunoglobulin concentrations were reduced as follows: IgG 4.1 g/l (normal 8-18 g/l), IgA 0.3 g/l (0-9-4.5 g/l), and IgM 0.6 g/l (0-6-2-8 g/l). Anterior mediastinotomy was performed. A thymus was removed, which was histologically of spindle cell type.

During follow up of one year the patient remained well with no recurrence of diarrhoea. The liver and spleen remained enlarged. The haemoglobin concentration returned to normal, but the lymphocytosis, abnormal lymphocyte subsets, and hypogammaglobulinaemia persisted.

Comment

Anaemia and hypogammaglobulinaemia associated with an excess of suppressor lymphocytes are well recognised as adjuncts of thymoma and may persist after thymectomy.1 Both recurrent and prolonged infections with C jejuni have been reported in patients with hypogammaglobulinaemia.1,2,3

On rectal biopsy campylobacter colitis usually appears as a focal, non-specific colitis, although poorly formed granuloma have been observed.4 In this patient a confident histological diagnosis of Crohn's disease was made. This was supported by the protracted course of the illness, weight loss, and anaemia. The prompt and sustained clinical response to treatment with erythromycin and the subsequent normal rectal biopsy appearances, however, militate against this diagnosis. We propose that the chronicity of the infection in this immunodeficient patient led to the formation of granuloma. The distinction between Crohn's disease and colitis due to campylobacter infection is important. Failure to recognise the unusual clinical and histological

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presentation of campylobacter infection in immunodeficient patients may result in inappropriate treatment.


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Skull radiography in epilepsy, dementia, and non-specific neurological symptoms

Despite the development and widespread use of computed tomography, skull radiographs continue to be ordered routinely, often as a prelude to computed tomography. Recent reports of studies to evaluate skull radiographs in trauma and psychiatric illness contained only limited references to the unique diagnostic information provided by skull radiographs compared with computed tomograms. Our study was designed to determine whether skull radiography could provide any important diagnostic information not available from computed tomograms in patients presenting with epilepsy, dementia, or non-specific neurological symptoms.

Patients, methods, and results

During 12 months 367 patients were referred for computed tomography. They had a presumptive diagnosis of epilepsy or dementia or were suffering from headache, vertigo, or blackouts without any focal neurological signs or papilloedema. Those patients who had not had a series of skull radiographs within the preceding week underwent a full four film skull series on the same day as the computed tomography. Computed tomography was performed with an EMI 1010 head scanner. The abnormalities seen in the scans were compared with those detected in the skull radiographs.

Skull radiographs showed abnormalities not seen on computed tomography in 14 of the 367 patients. These consisted of five skull fractures, five cases of sinus disease, and one case of each of hyperostosis induced by tumour, signs of raised intracranial pressure, enlarged middle meningeal markings, and craniospina. In every case the abnormal skull radiograph finding was seen in the lateral skull radiograph alone.

Comment

The diagnostic yield achieved by computed tomography in patients presenting with dementia, epilepsy, and non-specific neurological symptoms without signs has been reported previously. In only 14 patients did the skull radiograph show diagnostic features not shown by computed tomography. Although the enlarged middle meningeal vascular markings and hyperostosis induced by tumour helped confirm the diagnosis of meningioma in two cases, the skull radiograph findings did not actively cause the management of any of the patients to be changed.

Our finding that all the abnormalities were evident in the lateral skull radiograph accords with the findings of Bull and Zilka. They recommended that in the absence of physical signs a lateral view of the skull plus an anteroposterior projection to show the position of the pial gland (if it is shown to be calcified in the lateral projection) is all that is initially required.

Computed tomography performed with modern third and fourth generation scanners is preceded by a computerised radiograph generated by the scanner. The quality of this computerised radiograph is such that in a recent study of computed tomography in trauma it detected 20 of 21 fractures of the skull.

The results of this study indicate that once the decision has been made to investigate patients with epilepsy, dementia, and non-specific symptoms without neurological signs by computed tomography a skull series should not initially be performed. If it is decided that computed tomography is not initially indicated, or facilities for computed tomography are not easily available, a lateral skull radiograph, plus an anteroposterior radiograph if the pial gland is calcified, is all that is required.

1 Royal College of Radiologists. A study of the utilisation of skull radiography in accident and emergency units in the UK. Lancet 1980;i:1234-7.

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Spontaneous separation of fused labia minora in prepubertal girls

Llabial adhesions or fused labia minora are a common problem in prepubertal girls. They are harmless but must be differentiated from anatomical abnormalities. Commonly they are asymptomatic, though they may be associated with apparent urinary symptoms. Patients are referred to surgical clinics usually because their parents fear an abnormal development of the external genitalia. Occasionally the adhesions are an incidental finding during the course of routine examination. Topical oestrogen cream has been advocated as effective treatment. Alternatively, separation under general anaesthesia, except in very young infants, has been recommended. Treatment has been urged for these children in case more dense adhesion develops. This study was undertaken to determine whether any intervention is necessary.

Patients, methods, and results

Over three years 10 girls aged from 10 to 22 months were seen in the outpatient department by one surgical firm and subsequently followed up. Two other girls were lost to follow up. The diagnosis of labial adhesions was the principal reason for attendance in nine; in the tenth diagnosis was an incidental finding at examination. In each case the parents and, when appropriate, the patient were reassured and no further action was taken. The patients were then re-examined at 6, 12, and, if necessary, 18 months.

After six months five of the 10 showed complete and spontaneous separation, four partial separation, and one no change. By 12 months nine cases had resolved, and by 18 months all 10 had resolved completely. Adhesion did not subsequently recur in any of the patients.

Comment

Treatment for fused labia minora with local oestrogen cream has an incidence of success of about 90%; and was recently stated to be the treatment of choice. Side effects, however, have been reported. Airiarg found that reversible vulval pigmentation developed in all patients, one also developing vulval erythema, and adhesion recurried in one girl. Capraro and Greenberg noticed a slight incidence of breast enlargement and tenderness. We have seen a child in whom adhesions recurried after the application of oestrogen cream had been stopped. Moreover, this treatment requires good compliance by patient and parent and may be resisted by the child.

Surgical separation is long established and still has its advocates. However, patients undergo surgery when they are only a few months old, they have to be anaesthetised and may suffer undue distress. The stress of admitting a child to hospital and the potential risk of a general anaesthetic led us to undertake this study. Furthermore, the incidence of recurrent adhesions has been reported to be as high as 20%. Conservative management in our series led to an incidence of spontaneous separation of 100%, albeit over 18 months, though half